Caring Homes Healthcare Group Limited

Frethey House

Inspection report

Frethey Lane
Bishops Hull
Taunton
Somerset
TA4 1AB

Tel: 01823253071
Website: www.caringhomes.org

Date of inspection visit:
14 August 2019
15 August 2019

Date of publication:
27 September 2019

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Frethey House is a nursing home providing personal and nursing care to people aged 65 and over. At the time of the inspection there were 29 people living at the service. The service is registered for up to 41 people with nursing needs, it is not a specialist service for people living with dementia or mental health needs. The accommodation is arranged over two floors with two units on each floor. The downstairs units are called Hawthorn and Bramble. The two upstairs units Willow and Rowan are accessed via separate staircases.

People's experience of using this service and what we found
There have been four changes of manager at the home since November 2018 and a number of staff had left. These rapid changes had destabilised the home and adversely impacted on people's quality of care and on their confidence in the service.

A new manager was appointed in May 2019 although they were on leave when we visited. They had begun to make improvements and further improvements were planned.

People and relatives said, "It has been lacking leadership, you need good leadership, that filters down," "Good staff are not staying" and "It is a mixed experience lately, a lack of communication and direction."

Staff vacancies and short-term sickness were affecting recommended staffing levels and there was high use of agency staff. People and relatives said; "The staff do their utmost and are very attentive when they come, but they don't have the time." Following the inspection, the provider increased staffing levels.

People did not always receive safe care and treatment. Improvements were needed in medicines management and in minimising environmental risks. People's risk assessments lacked detail to guide staff on how to minimise risks.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Improvements were needed in consistently assessing people's mental capacity and in documenting best interest decisions, particularly about the widespread use of pressure mats and bedrails. Also, in involving people's representatives and families in best interest decisions, where people lacked capacity.

People spent a lot of time in their rooms and there wasn't enough to occupy them, and relatives were worried about isolation. A second activity co-ordinator had just been appointed, so work was underway to improve activities.

Although recent improvements in quality monitoring had been made, these were not fully effective. Care records lacked detail about how to meet people's individual needs. There were gaps in daily records and

people's care plans were overdue for review and were not always up to date about their needs.
People did not always receive person-centred care and treatment that was appropriate, met their needs and reflected their personal preferences. People were offered opportunities to take part in activities, although activities were not personalised to meet people's interests or their specific needs. Efforts were underway to improve these.

People's feedback about the quality of food and choices on offer was mixed. Some improvements had been made and more were planned. People who needed support to eat and drink did not always receive the support they needed.

People said they felt safe. Families were made welcome and could visit anytime.

Five breaches of regulations were found at this inspection. These related to failures in dignity, consent, safe care and treatment, good governance and staffing. Further actions were needed to address risks and make required improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection: Good (Report published March 2017). At this inspection the rating has deteriorated to requires improvement.

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Please see the action we have told the provider to take at the end of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led

Details are in our well led findings below.

Frethey House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection team included two inspectors, a specialist nurse advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Frethey House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a new manager who was not yet registered with the Care Quality Commission but had applied to register. The provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. We visited the service on 14 and 15 August 2019.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection

We spoke with 14 people, six relatives and two friends to ask about their experience of the care provided. We looked at 11 people's care records and at five people's medicine records. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the operations manager, 13 members of staff including nurses, a staff trainer, care workers, kitchen, housekeeping, maintenance and administrative staff. We looked at three staff files in relation to recruitment and at information about staff training and supervision. We reviewed a range of quality monitoring records, such as audits, policies and procedures as well as at servicing and maintenance records.

After the inspection
We spoke with the new manager and with four health and social care professionals who regularly visited the service to get their feedback.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● People were at increased risk because of staffing and skill shortages. Following four changes of managers since November 2018, a number of staff had left. People and relatives were concerned about the loss of staff they had got to know and trust. Several were unhappy with people's care and support and felt standards of care had dropped.

● People's comments on impact of staff changes included; "We have lost so many good staff. They are very short of staff and they are overworked," "The staff change an awful lot and standards have dropped," "There are agency nurses nearly all the time. I am very disappointed," Relatives said, "Staff are thin on the ground at times, especially at weekends," "We don't see staff often, they are busy. They don't come in when I am here……I'm not sure how often they check [person's name]."

● A dependency tool was used to determine number and skills of staff needed. This showed a number of people living at the home had high levels of dependency, so needed staff to anticipate their needs.

● Short term, gaps in the staffing rota were being filled with existing staff working extra hours and by agency staff. Where staff were inexperienced or unfamiliar with people' needs, this was having a negative impact on people's quality of care and creating increased risk.

● Rotas and staff feedback showed recommended staffing levels were not being consistently maintained due to high staff sickness levels. Staff comments included; "It's been appalling, some days there were only three care staff for the whole place," [Normally six care staff in the mornings, five in the afternoon]. Other staff said, "We are told to leave as many people in bed as possible," "I sometimes have to cover the kitchen for supper, so then I'm off the floor."

● Staff described impact of low staffing for people's care on days when they weren't enough staff. This included people being washed and dressed later in the morning and having to remain in their rooms. Staff were reluctant to bring people downstairs to the lounge or dining room if there was no activity co-ordinator on duty, as there was nothing to do. Also, they were worried that some people with behaviours that challenged the service might upset others, when there were no staff present to support them.

● On both days we visited we saw occasions when people needed staff support but didn't receive it. People were calling out for staff, who passed by but did not respond or there were no staff nearby to hear their calls. Upstairs on the second day, there was a lack of staff available to supervise and support people to eat in their rooms. This caused distress, food spills and dignity issues for people. On each occasion we had to locate senior staff and ask them to arrange for staff to respond to those people's needs, which they did.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, we spoke with the manager to find out what further steps were being taken to improve staffing. The provider authorised an additional member of care staff to be on duty each day. This was to increase the support people received whilst new staff were undergoing induction. Two nurses were being transferred from another service short term to support the nursing team. The manager did not plan to admit any more people to the home until they were confident the service could meet their needs.
● Additional staff had been recruited and were due to start work in the next two weeks. To minimise risk, new staff and agency staff were rostered to work with experienced staff who knew people well.
● On occasions where there were enough staff, we saw people received appropriate support. For example, a staff member sat and helped a person eat their lunch in bed at a relaxed and unhurried pace and chatted companionably to them. Where people were confined to bed and needed frequent checks, their charts showed these were mostly carried out.
● Staff had been safely recruited. All staff pre-employment checks to check suitability had been carried out before staff started working with people. For example, criminal record checks, and obtaining references from previous employers.

Using medicines safely
● People were at increased risk because they did not always receive their medicines safely or on time. For example, a person had not received five prescribed doses of a medicine vital for managing their medical condition at the beginning of the month because it wasn't available. Since then, two further prescribed doses had been missed due to staff administration errors. Another person's prescribed medicines had been administered incorrectly, which had resulted in them receiving a higher dose than was prescribed.
● We found tablet counts we checked for several people's medicines were incorrect. We were unable to confirm with staff whether or not these were missed doses, or incorrect tablet counts. This meant not all medicines could be accounted for. Nursing staff explained this was the first month of a new medicines system, so they were still getting used to the new system.
● People said they were supported by staff to receive their medicines on time. However, we found a discarded tablet on a person's table and a staff member said they regularly found tablets in people's rooms. This could mean nursing staff don't always stay until all tablets have been taken.

Assessing risk, safety monitoring and management
● People had individual risk assessments in place, but these lacked guidance for staff about care needed to reduce risks. For example, where a person needed hoisting, there were no details for staff about which hoist or the sling size that should be used, which could mean incorrect equipment was used.
● Where people living with dementia had behaviours that sometimes challenged the service, their care records lacked details for staff to follow about how to manage these. For example, about triggers that could affect a person's emotional well-being or steps staff could take to take to distract the person and avoid them becoming anxious or upset.
● We identified some environmental risks for people which included an electrical room, storage cupboard and sluice rooms which were supposed to be kept closed/locked were left open. This could mean people living with dementia or visiting children might access hazardous equipment and chemicals.
● Thickeners used for drinks for people with choking risks were left on tables/locker instead of being securely locked away, which could cause harm if eaten. We brought them to the attention of staff, who addressed this issue. Ongoing vigilance was needed, so people were protected.

The above demonstrates a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, we followed up medicines' management risks with the manager. They were

aware from medicine audits of most of the issues we highlighted and were working to improve them. For example, through additional staff training, supervision and by raising awareness of common errors at staff meetings. For the forthcoming month, they had checked all the medicines delivered to ensure they were all available. An experienced nurse was planned to be on duty at the beginning of the next monthly cycle, who was familiar with the new procedures.

● Staff who knew people well were familiar with people's needs/risks, so they could support agency and new staff. The manager had identified and prioritised prevention and management of falls, pressure ulcers (sometimes known as bedsores) and nutritional risks as key areas for improvement and taken steps to improve care in these areas. For example, by using fall booklets to personalise additional steps needed for people at high risk of falling. Also, by raising staff awareness and seeking professional advice.

● Systems were in place to ensure equipment was safe and in good working order. For example, checks of fire safety equipment, hoists were serviced regularly, as was the passenger lift. Monthly equipment checks were carried out on hoists, slings and wheelchairs.

● Improvements to the environment were being undertaken during the inspection. For example, carpets were being replaced with new flooring and decorators were painting corridor areas. We fed back concerns about a leak and an area of stained plaster a person brought to our attention, which maintenance staff said they would address.

Learning lessons when things go wrong

● Staff completed accident/incident forms, which were checked by the manager to ensure all necessary actions had been taken to reduce risk. For example, minimising falls risks for people by making sure they wore well-fitting footwear and making sure bedroom and corridor areas were free of slips, trips and falls risks.

● The manager monitored accidents and incidents monthly to try and identify anyone at increasing risk and to check for any trends that needed further action. For example, to identify if there were times of days or places in the home where people had more accidents.

Systems and processes to safeguard people from the risk of abuse

● People said they felt safe living at the home. One person said, "I feel safe, everyone is good to me and do the things I need." Safeguarding information was displayed on notice boards.

● People were protected from potential abuse and avoidable harm. Although some staff had not yet received safeguarding training, all staff we spoke with knew about the different types of abuse. They knew what to do if they had concerns about a person's welfare and felt confident to raise these with nursing staff and the manager.

Preventing and controlling infection

● People were protected from cross infection. Improvements in cleanliness had been made and the service was clean and odour free. Staff had received training to ensure they worked safely, and had access to appropriate protective clothing, such as gloves and aprons.

● Cleaning staff were on duty each day and followed a cleaning schedule and responded to any urgent needs. Housekeeping staff said there should be two cleaners and a member of staff working in the laundry each day, but this rarely happened, so they struggled to maintain standards.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We checked whether the service was working within the principles of the MCA/DoLS and found instances where they were not.

- A number of people who lacked capacity were subject to restrictions on their liberty for their safety but without the proper authorisations in place. For example, mental capacity assessments and best interest decisions had not been completed for several people with bed rails and pressure mats. (Pressure mats are devices which set off an alarm when people step on them to alert staff).
- Feedback from relatives about their involvement in decision making was mixed. A relative with legal power of attorney for care and treatment decisions was not consulted or involved in a best interest decision about the use of a pressure mat outside the person's room. This restriction meant the person could not move freely around the home. Care records did not contain clear information about whether relatives held a power of attorney for decisions about people's health and welfare or their finances.

This was a breach of regulation 11 (Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The manager had identified these issues and was addressing them. They had arranged for a dementia lead from head office to visit the service, who had undertaken mental capacity assessments for some people who lacked capacity and were subject to restrictions on their liberty for safety reasons. Retrospective DoLS applications for people had been submitted to the local authority DoLS team, where restrictions were in place. Some best interest decisions had been documented, although these did not include details of how

legal representatives or family members were consulted and involved.
● Staff sought people's consent and offered them a choice before supporting them. For example, about personal care and how they wished to spend their day. One person said, "They [staff] ask my permission."

Staff support: induction, training, skills and experience
● People's comments about staff skills were mixed. People were positive about the skills of staff they knew. Comments included, "They know what they are doing, they are very good." However, people felt less confident about the skills of new and agency staff. They said, "I have a groan when it's an agency staff. I haven't felt unsafe, but not as much at ease as if it was a fully trained, proper carer," "Some of the agency [staff] are not quite sure what they are supposed to do."
● Several people living at the home were living with dementia. Some staff lacked skills and knowledge about the most effective ways of interacting with people living with dementia. A relative said, "I want [relative] to go downstairs but he seems to have been left in his room. He hasn't got capacity, but staff could be a little more persuasive. It's about how they say it." The manager had identified dementia training as a priority need for all staff. They also planned other update training such as tissue viability training for nurses.
● Staff new to care confirmed they had completed an induction which included the care certificate. However, several new staff had still not completed the provider's mandatory training such as fire safety, moving and handling, health and safety, record keeping and safeguarding. Due to staff turnover, some existing staff were overdue for update training as they could not be freed up to attend training. For example, safeguarding, health and safety, first aid and infection control.
● The manager was taking steps to get all staff training up to date. The provider's in-house trainer was planning to be based at Frethey House from the following week to support on site staff training.
●The provider had a comprehensive training programme, which included first aid, health and safety, moving and handling and care planning. Staff had access to training and development relevant to people's needs. For example, continence care, diabetes, nutrition and healthy eating.
● Due the changes in management at the service, staff supervision had lapsed for a few months. However, since May 2019 the new manager had put a new supervision schedule in place and most staff had received at least one supervision session.

Supporting people to eat and drink enough to maintain a balanced diet
● People's feedback about the quality of food and choices on offer was mixed. Most people were happy, but others wanted more improvement. People's comments included; "Lunch today is lovely," "It can be absolutely perfect, some days, in the evening, it's not so nice," "I am not happy with the food." Others said, "It hasn't been very good until the new manager came. It has been a bit more varied recently," "This last fortnight we have had some changes to the menu which have been very welcome."
● The manager had identified improvements in the quality of food were needed and efforts were underway to do so. A new chef had recently started working at the service and a head chef was being recruited. In the meantime, staff from head office had visited the service to review menus and make changes.
● Kitchen staff were aware of people's dietary needs, likes and dislikes and any allergies. Where a person was not eating dairy, they used goat milk products when preparing the person's food. The chef was aware of those people who required a modified diet and prepared pureed foods for people with choking risks.
● People's mealtime support experience was mixed. On the first day of inspection people were well supported at lunchtime. On the second day, a lack of staff availability meant three people struggled but there were no staff around to notice or assist.
● People were offered drinks throughout the day and were encouraged to increase their fluid intake to keep hydrated. Records of food and drink were maintained for people at risk, although could be more detailed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were assessed before they began to use the service. Assessment records we looked at had basic essential information, but did not include all health, personal care, emotional, social, cultural, religious and spiritual needs. For example, some people's records we looked at didn't include all relevant health needs related to their dementia, and the impact on their mental wellbeing. This meant there was a risk staff did not always have all the information they needed to meet people's individual needs.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● Following several notifications to CQC over past few months about people who had developed pressure ulcers (bedsores), we looked in detail at those people's care. We found improvements had been made in the assessment, treatment and monitoring of people with wounds.

● People at risk of skin damage were repositioned regularly to prevent skin damage. They had appropriate pressure relieving equipment such as pressure relieving mattresses and cushions. The service sought specialist advice appropriately which was incorporated advice into individual wound care plans. A relative said, "There was an issue, within two weeks [relative] had a sore, but since then it's been exemplary." A health professional said, "Staff have a fair understanding of preventing pressure damage, I haven't had any significant concerns."

● People were happy with the healthcare support they received. One person said, "The nurses are very, very good. They will send for the doctor or to the surgery to see the practice nurses [re ear problems]. They also take me down to the hospital, which is not far."

● Staff worked in partnership with other professionals to meet people's health and care needs. Records showed people had access to a variety of health professionals. For example, their GP, speech and language therapy, occupational therapy, podiatry and opticians. During the inspection, an occupational therapist visited to assess several people for more suitable seating.

Adapting service, design, decoration to meet people's needs

● Some aspects of the environment were adapted to meet people's needs but others needed improvement. For example, corridors were wide, and bathrooms and toilets were accessible for people using wheelchairs and mobility aids. However, people's bedroom doors were all painted white, so they looked the same and there was a lack of suitable signage. This meant it was difficult for people to navigate independently around the home or find their way upstairs, particularly if they were living with dementia.

● The manager outlined the providers development plans to make the service more dementia friendly, for example, by using dementia friendly signage. Also, plans to change the layout of the lounge and dining areas to connect them. This would make those areas more suitable for people's needs and make it easier for staff to support people in those areas.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

● People were not always treated as individuals or with dignity and respect. Upstairs on the second day, people having lunch in their rooms did not receive the support and supervision with mealtime they needed. For example, one person tipped their plate of food all over themselves. Another person had dropped some on the floor and was picking it up and placing it in their mouth. Staff were busy fetching people's lunches, so there were no staff nearby to notice or respond.

● We heard a person calling out for several minutes, with staff passing the person's door but not responding to them. On three other occasions, we heard three people calling out for staff in a distressed way, but there were no staff nearby to respond. On each occasion, we made senior staff aware, so they could arrange the support they needed.

● A relative said they were unhappy with standards of personal care and felt standards had dropped in the past few months. They said some days the person looked "shabby," their hair was not always brushed, fingernails were dirty and sometimes the person was not wearing their own clothes, or appropriate underwear. Their relative said, "[Person's name] was a fine dresser and took pride in her appearance, it's so sad to see." Another relative said the person was unshaven some days, and thought the person sometimes slept in the clothes they wore during the day."

● Two people said they couldn't have a bath or shower as often as they wished. One said, "I haven't had one bath a month since I have been here. I have spoken to each of the managers, but they can't do it if they haven't the staff." Another person said, "I think I had one [bath] about 10 days ago."

This was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We followed concerns about bathing up with nursing staff who made us aware of other people who were having a bath/shower more often than that. However, it was difficult to confirm from people's personal care records what choices had been offered and whether the personal care given was a bath, shower or wash. The operations manager undertook to remind staff to make sure people were offered bath/shower options more regularly. They also made immediate changes to personal care records, so they more accurately captured people's daily person care.

● People said most staff were excellent, very kind and caring and they were complimentary about the approach and attitude of staff. Comments included, "The staff are excellent, very kind and caring. They don't rush me and are never rough," "We get into conversations and have a laugh together," and "The very best

thing is the staff, they are wonderful and do all they can in their limited time with us."

● People said staff encouraged them to retain their independence. One person said, "I think they do encourage me to be as independent as possible. I use a walker. Someone walks with me, which makes me feel a lot better, more confident." A person's care plan showed they needed staff to remind them to wash and clean their teeth due to their dementia. Another person had a two handled beaker, so they could drink independently without spills.

● People's visitors were welcome, and we saw family and friends coming and going throughout the day. Relatives said staff worked hard and were kind and caring. Comments included, "Staff look after (person) very well, they are very good here" and "The permanent staff are gems, the nurses excellent."

● People's faith was maintained because local church representatives visited, and services took place regularly at the service. However, one person of another faith had expressed a wish to reconnect with their local church community by going to church weekly. Plans to support them with this had not progressed, so we asked staff to follow this up further.

Supporting people to express their views and be involved in making decisions about their care;

● People confirmed staff involved them in day to day decisions. One person said, "I can go to bed when I want." Another person described how they were eating breakfast and said they did not like it. "The staff member asked me 'what would you like?' The next day she brought me cereal, with hot and cold milk. There was a dish of strawberries and slices of brown toast. She listened to me, she's lovely."

● Although some people and families reported being involved in reviews of people's care, this was not clear from people's care records.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People did not always receive person-centred care and treatment that was appropriate, met their needs and reflected their personal preferences. For example in relation to times they wished to get up and how they spent their day.
- Standards of record keeping needed improvement. People's care plans lacked detail, some were overdue for review and some were not updated to reflect people's changing needs. This meant there was a risk staff, particularly new and agency staff did not have all the information they needed to respond to people's individual needs. For example, one care plan said a person could verbally communicate but their relative said they could no longer do so.
- There were gaps in some people's food and drink intake records. We couldn't be sure whether those people had enough to eat and drink, or whether these were recording errors.
- We identified concerns about a person who had lost weight. Their nutritional risk assessment showed the level of weight loss indicated staff needed to take further actions to prevent more weight loss. Staff had not recognised this so had not commenced a more detailed nutrition care plan.

This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We highlighted this to nursing staff, who had put a nutrition care plan in place the following day. This outlined additional steps being taken to prevent any further weight loss such as use of nutritional supplements.
- Care record audits showed the manager was aware care records needed improvement and were working with staff to achieve this. Although care plans lacked detail, several people were happy with the care provided and felt staff knew them well.
- Feedback about response call bell response times was mixed, some people said they didn't wait long but others described longer waiting times. Comments included, "Timing, sometimes it's perfect and sometimes it's not," "I have to wait 15 minutes, and that's desperate sometimes," "On the whole it's not too bad."

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People spent a lot of time in their rooms and there wasn't enough to occupy them. Some people were able to confirm this was their choice, but others were not. There was an activity programme in place, however, due to staff changes activities had decreased. The activity co-ordinator spent most of their time trying to see people in their rooms, which limited their availability for group activities in communal areas. A

staff member said, "If [name of activity co-ordinator] is not in we don't bring people downstairs as there is nothing to do."
● One person said, "I would like to go to town now and again. A relative said, "[Person's name] sits in her chair all day, there is little stimulation, no meaningful things to do. She is on her own a lot and would benefit from being more sociable in the lounge."
● The manager had recognised this, and a second activities staff member had just been appointed. People's said: "The activities have been pretty lacking. I have met the new person who I think will improve things a lot," "Now they have another activities person, things definitely have improved. There are quizzes, music, puzzles, sitting around and chatting, trips, tea parties. There is a minibus and we went to a farm shop."
● We observed some organised activities in lounge, which included playing games, chatting and looking at photos of a recent trip out. Other activities people enjoyed included musical entertainment, an exercise class and visiting animals.
● Although currently activities were not personalised to people's individual needs and interests, work was underway to improve this. The activity co-ordinators were speaking with people and families to gather more details about their past life, social interests and hobbies. For example, one person was telling the new activity co-ordinator about their work at a bank and discussing their love of cats and dogs.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Care plans provided information about people's sensory or hearing impairment. For example, whether they needed a hearing aid or glasses to improve communication.
● One person had limited sight. They said, "I have a talking clock and a magnifying glass, but it's not strong enough for smaller print." They said staff were very helpful, and would read them anything they needed, such as letters. Another person was deaf, so staff had turned on the text display on their TV, so they could follow the programme.

Improving care quality in response to complaints or concerns
● People said they would speak with the staff or manage if they had a complaint or concern. There was information in people's bedrooms about how to make a complaint.
●Two people said they had not made a formal complaint but had raised some concerns with the manager in the past but had not seen the improvements they had hoped for. Another person had raised a concern about a member of staff. They said, "I reported it and things got better." Relatives had also raised concerns with the manager. These had been followed up through individual meetings.

End of life care and support
● One person was receiving end of life care during the inspection. Staff had worked with person's GP and hospice staff to make sure the person was kept comfortable and pain free. Their relative praised the care and kindness of staff and their support for the person and the family. They said, "Her care has been amazing." A member of staff said, "I think it's done quite well, we include the family and their wishes, we want the residents to be pain free and comfortable."
● The service had advanced care plans staff could use to capture people and families' preferences and wishes about their end of life care. However, these had not been completed in most people's care plans. This meant personalised information about people's end of life wishes such as any preferred funeral arrangements were not captured.
● Each person had a Treatment Escalation Plan (TEP) in place. This recorded important decisions about

whether or not the person wanted life-prolonging treatment or admission to hospital if their health deteriorated.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There had been four changes of manager at the service since Nov 2018. This had dented the confidence of people, families and staff in the leadership of the service. The loss of the clinical lead and the lack of senior care staff was also causing communication and organisational issues.
- People and families spoke about the disruption of frequent management and staff changes. People said, "There is no leadership here, several managers have come and gone. I haven't met the new manager yet," Relatives said, "The recent changes have been ridiculous, four changes of manager in just a few months," "My main concern is the management of the service. What they never do is manage, they never anticipate issues, so just let them happen."
- Staff also spoke about destabilising effect of frequent manager changes and feedback about staff confidence and morale was mixed. Staff said, "It's difficult to get used to all the changes, things change with each new manager, it's very unsettled," and "We feel we are not listened to." Others spoke about conflict within the staff team. Staff comments included; "Things are not great, morale is low" and "The [new manager] struggles with how to speak with us and can be abrupt."
- Although improvements in quality monitoring had been made but these were not yet fully effective. Five breaches of regulations were identified at the inspection in relation to dignity and respect, consent, safe care and treatment, good governance and staffing.

This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- An experienced new manager was appointed in May 2019 and had applied to the Care Quality Commission to become the registered manager. They explained they had inherited some problems but were keen to develop an open and inclusive culture.
- Some staff had seen improvements under the new managers' leadership, that the service felt better organised and cleanliness had improved.
- The manager had reinstated lapsed quality monitoring arrangements and introduced additional systems such as mattress and bedrails checks. Completed manager audits showed they were aware of areas where the service was not meeting the requirements of the regulations and were tackling these. For example, standards of record keeping.

●The manager was around the service each day, observing staff interactions with people and assessing staff skills. Where any concerns about individual staff performance were identified, these were dealt with through training, supervision and where necessary, disciplinary processes.
● At daily handover and staff meetings the manager discussed with staff how best to support individuals, and reviewed any incidents, accidents or safeguarding concerns. They had developed a written handover sheet, so staff unfamiliar with people were given essential information about their care needs and any risks.
● The manager used an improvement action plan to monitor areas needing improvements and this showed progress had already been made. The provider had arranged extra support for the service. The operations manager was spending extra time at the service to support the manager. Staff from head office were spending time at the service. For example, to help get training up to date, completing mental capacity assessments and DoLS applications and on supporting kitchen staff to improve the quality of food.
●The provider had a programme of ongoing improvements to the environment. Flooring was being replaced and corridor areas were being redecorated. Future improvements to change the layout of lounge and dining room areas and to link them were planned. When completed, this will make it easier for people to move around and enable staff to provider better support for people using those areas.
● Speaking about improvements relatives said, "Staff are pushed to their limits. It is improving but will take a long time to get it right," "The new manager knows her job" and "It feels like it's getting better now." The operations manager said, "Recovery is still fragile, we want to see it embedded."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● Where mistakes were made, the manager was open and honest with people and families and made improvements. For example, when accidents or incidents occurred, families were informed. This included steps being taken to further reduce risks for people.
The provider also had whistleblowing policies and a provider hotline, so staff could report concerns directly, if they felt concerns were not listened to.
● The operations manager said the manager was being honest with people and families about the difficulties around staffing and some families were reporting progress. They said, "Things are on the up, but we need to be realistic."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and families were consulted and involved in day to day decisions about the running of the home day to day and through regular meetings. Areas discussed included introducing new staff, menu choices, and suggested activities.
● Resident/relatives' meetings were held in May and July and further meetings were planned, including a weekend meeting to try and connect with more families. People and relatives who attended discussed activities, as well as food likes/dislikes to help with menu planning. There were plans for a summer barbeque and a cupcake day to raise funds for a charity.
● The service used surveys to seek ongoing feedback. A "You said we did" board in hallway gave feedback about actions taken in response. For example, in relation to food and providing a wider range of activities.

Continuous learning and improving care; Working in partnership with others
● Plans to pursue the Gold Standards Framework (GSF) were on hold due to staffing difficulties but would resume once all new staff were in post. This is an evidence-based quality framework, which enables earlier recognition of people with life-limiting conditions. This helps people to plan and live as well as possible to the end of their life.
● The manager was reviewing the skills and experience of care staff to identify suitable staff for further

development to more senior roles, and to attend the providers' care worker development programme.

● An activity co-ordinator had attended two training courses to improve activities. The activity co-ordinators planned to use technology more to enhance people's experience. A new TV had been purchased for the lounge and they planned to purchase a laptop for the service. This was so they could better connect with people to reminisce with them about their favourite music, films, places they had lived and visited.

● Staff worked in partnership with health and social care professionals such as occupational therapists and physiotherapists to improve people's care. The service had established links with the local church.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People were not always treated with dignity and respect. Where people were not adequately supported, particularly at mealtimes, this caused distress and dignity issues.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	People's consent to care and treatment was not always sought in line with legislation and guidance.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Not all risks to people's health and well-being were effectively managed. People did not always receive their medicines safely or on time. People's risk assessments lacked detail for staff about the care they needed to reduce risks. We identified some environmental risks for people, as rooms which should be secured were left open.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	People's care records and risk assessments lacked detail to instruct staff about their care

and treatment needs. Quality monitoring systems had not sufficiently mitigated risks relating to the health, welfare and safety of people using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were at increased risk because of staffing and skill shortages. Where staffing levels were low, or staff were inexperienced or unfamiliar with people' needs, this had a negative impact on quality of people's care and treatment.